Equitable Access to Abortion Care in Hawai'i: Identifying Gaps and Solutions

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Abstract

Despite a progressive legislative landscape, some women in Hawai'i lack access to abortion care. Those in the military, undocumented immigrants, and people living in rural areas and on neighbor islands face significant barriers to timely and affordable abortion care. Evaluating these gaps in access can help identify key areas for policy improvement to ensure health equity in Hawai'i.

Introduction

Induced abortion in the United States is safe, common, and constitutionally protected. With nearly half of all pregnancies in 2011 being unintended and 40% of those ending in abortion, abortion is one of the most common medical procedures performed in the United States.[1,2] Although abortion rates have been declining over the past decade, one in four women in America will have at least one abortion by the age 45.[3] In 2014, there were 2,147 abortions reported in Hawai'i at a rate of 8 abortions per 1,000 women aged 15-44.[3] Abortion patients are not monolithic—they are diverse in race, family income, relationship status, sexuality, citizenship, and employment.[3] The majority of abortion patients in 2014 had a previous birth, were in their 20's, and lived below the federal poverty level.[3]

In 1970, Hawai'i became the first state to legalize abortion and continues to lead the nation in access to abortion through public funding and insurance coverage.[4,5] Despite a progressive legislative landscape, some women in Hawai'i still lack equitable access to abortion care. The barriers to abortion care in Hawai'i include cost, insurance coverage, geography, immigration status, and provider shortages. This article explains these gaps in access and proposes ideas to solve them locally and nationally.

Financial Barriers to Abortion Care in Hawai'i

The Hyde Amendment was first passed in 1976 and prevents the use of any federal funding for abortion care except in a few extreme circumstances.[6] Therefore, any person with insurance funded by the federal government (TRICARE, Medicaid, CHIP, Medicare, federal employees, diplomats) must pay for their abortion out-of-pocket. Active duty military members, their spouses, their children, military civilians, reservists, and veterans all receive health insurance through the federal government.[7] The Hyde Amendment therefore excludes a large number of people in Hawai'i from abortion care coverage. The State of Hawai'i has eleven military bases and as of September 2017, there were 36,620 active duty service members, 9,402 reservists, and 18,739 military civilians stationed or living in Hawai'i.[8,9] Although these statistics do not equate to the exact number of women of reproductive age insured through the military in Hawai'i, they do illustrate that a significant number of women in the state depend on military insurance for health care. This group of women also lack abortion benefits in their insurance coverage. With unintended pregnancy rates higher among servicewomen than the general population, this lack of coverage for an essential health service serves as a great injustice for service members and their families living in Hawai'i.[10]

Although the Hyde Amendment also bans the use of federal funds to pay for abortion through programs like Medicaid, Hawai'i uses state funds to cover abortion related expenses for Medicaid beneficiaries.[11] This state policy allows many of the women in Hawai'i living below the federal poverty level to have financial access to abortion care. However, not all women in Hawai'i living in poverty are eligible for Medicaid. Hawai'i not only requires that potential Medicaid beneficiaries be state residents, but also requires that they are US citizens or "qualified aliens."[12] In 2014, it was estimated that 3.2% of Hawaii's population was undocumented, accounting for nearly 45,000 people.[13] Therefore, undocumented immigrants in Hawai'i are ineligible for Medicaid benefits and must pay out-of-pocket for abortion care. This policy poses a significant injustice and financial burden for immigrant communities living below the poverty level. Nationally, out-of-pocket costs for abortion care range from almost $400 for first-trimester abortions to $1000 or more for second-trimester procedures.[14] Hawai'i, however, has significantly higher out-of-pocket costs for abortion care. Abortion providers report that first-trimester procedures start at approximately $800 - $1000 and second-trimester procedures are $2,000 - $5,000 out-of-pocket. An abortion can cost

over one third of the monthly salary for many women.[15] This significant financial barrier leads to delays in care, resulting in more expensive procedures at more advanced gestations or complete inability to access the desired abortion.[15] Inability to access abortion care due to financial constraints is not only a public health concern, but is also a matter of considerable injustice in our communities.

Solutions to Address Financial Barriers to Abortion Access in Hawai'i

In 2018, the Hawai'i State Legislature introduced Senate Bill 2341 and House Bill 2121 as solutions to financial barriers to abortion in the state. These companion bills would require all health insurers in Hawai'i to cover comprehensive reproductive health care services for beneficiaries, including abortion care, and expand Medicaid coverage to include non-citizens living below the federal poverty level.[16] This bill would close the coverage gap for some immigrants ensuring equitable access to abortion care, as well as other important reproductive health services like cancer screening, contraception, and prenatal care.

A similar bill, the Reproductive Health Equity Act, was successfully passed by Oregon's State Legislature in 2017. The Act was an expansive overhaul of Oregon's insurance code, reproductive health policies, and coverage requirements.[17] Among the many important women's health protections of this Bill, the Reproductive Health Equity Act prevents exclusion of people from health benefit plans based on national origin. Therefore, Oregon was able to successfully expand their state Medicaid coverage to include undocumented immigrants for prenatal care as well as abortion care. Analysis of the full health and health equity-related outcomes of this bill with regard to abortion access has yet to be published. However, expanding Medicaid coverage to undocumented immigrants in Oregon was shown to increase their numbers of prenatal care visits and well-child visits.[18] Therefore, reintroduction and passage of SB 2341/ HB 2121 to the 2019 Hawai'i State Legislature would not only expand abortion access in Hawai'i, but also improve maternal and child health.

Although SB 2341/ HB 2121 would require all health insurers in Hawai'i to cover abortion care, it is unlikely this requirement can be applied to the federally funded insurers of federal employees, service members, and their spouses. To address the abortion coverage gap for those with military or federal insurance, a novel approach to Medicaid coverage in Hawai'i could be undertaken. Specifically, eligibility requirements for Medicaid covering pregnancy could be changed to allow any person with insurance coverage that excludes abortion care to obtain emergency Medicaid coverage for those services. This approach to cover healthcare for service members has not been employed by any other state, but a healthcare policy that assists pregnant service members or their spouses in this way could be socially desirable.

Geographic Access Barriers

Approximately 90% of counties in the United States lack trained abortion providers, which contributes to the 26-43% of women nationwide who travel more than 50 miles to obtain these services.[19] Nearly 50% of women who are having abortions in the second trimester report having difficulties in finding or obtaining an abortion provider.[20] Geographic barriers to abortion care are more pronounced in Hawai'i than in other US locations, as patients cannot routinely drive to the closest clinic. Of the seven inhabited islands of Hawai'i, only 2 have abortion providers: O'ahu and Maui. Therefore, patients living on many neighbor islands also undergo significant geographic barriers to accessing abortion care.

In general, Hawai'i has a high cost of living with lower physician reimbursement in rural areas.[21] Rural communities on O'ahu and neighbor islands have significant primary care provider shortages.[22] Increasing health services in low population density areas of Hawai'i has been an ongoing struggle.[23] Lack of physicians in rural areas significantly reduces access to abortion services for women living in these areas of the state and requires air travel to obtain abortion care. Although advanced practice clinicians (APCs) can skillfully provide abortion care, Hawai'i lacks a diversification of its abortion provider workforce due to state level policies. Hawai'i is one of forty-one states that has a "physician only" law, stipulating that only physicians can perform surgical abortions.[24] This physicians-only law effectively decreases access to abortion services in rural areas of the state, which have marked physician shortages.

Lack of service availability on neighbor islands can require expensive airfare and accommodations on O'ahu to receive needed care.[23] While some insurance plans may cover the cost of travel and accommodations, this does not account for the cost of additional family members to accompany the patient, the cost of lost time from work, the cost of childcare, or other travel associated costs such as food and ground transportation. While distance to specialized services is a barrier for many people across the United States, Hawai'i faces unique barriers regarding distance due to separation from services by the ocean in this island state.

Solutions for Access to Care Issues in Rural Communities

One option to address the challenges for rural areas would be to expand the abortion provider workforce to include APCs such as nurse practitioners (NPs), certified nurse midwives (CNMs), and physician assistants (PAs).[20] These clinicians are more likely to care for underserved populations in rural areas, making them critical players in expanding healthcare services.[20] Abortion care by APCs is supported by the World Health Organization and evidence shows first-trimester abortion services provided by APCs are as safe as obtaining them from a physician trained in abortion care.[19,25,26] Currently, the District of Colombia and

nine states (California, Colorado, Conneticuit, Montana, New Hampshire, Oregon, Rhode Island, Vermont, and West Virginia) within the United States have no criminal laws or regulations that restrict first-trimester abortions to physicians only.[19] APCs in the U.S. who specialize in reproductive health services can acquire advanced skills through educational programs like those offered by the Association of Reproductive Health Professionals.[27] Provision of abortion services by APCs increases continuity of care, facilitates earlier diagnosis and termination of unintended pregnancies and increases the health and well-being of women.[27] The Hawai'i State Legislature routinely introduces a measure to remove physician only requirements for abortion care and adding this as a legislative priority for 2019 will work to expand abortion access to the geographically diverse areas of Hawai'i.

Modern approaches to administering medical abortion can also increase abortion access in rural areas without the need of surgical training for new providers. Medical abortion is a two-drug process where the medications mifepristone and misoprostol are taken orally to terminate a pregnancy within the first ten weeks.[28–30] The first medication, mifepristone, must be dispensed directly by a clinician in their office. The second medication, misoprostol, can be dispensed by a pharmacy and taken at home.[28] While this method increases access by eliminating the need for surgical facilities or trained surgical abortion providers, it still does not address access issues for women who have difficulties getting to a facility to obtain mifepristone. For example, the only abortion providers registered to dispense mifepristone in the state are located on the islands of O'ahu and Maui, which restricts medical abortion access to women living on neighbor islands.[29,30] Given the geography of the state, various models of telemedicine abortion are a good mechanism for administering mifepristone from registered providers at a distance through information and communication technology.[31]

There are two current models for telemedicine abortion: the clinic-to-clinic model and the direct-to-consumer model, also called TelAbortion. In the clinic-to-clinic model, the provider licensed to dispense mifepristone is at one clinic and the patient is at another clinic, usually in a more rural area. The patient has a routine diagnostic work-up at their rural facility and they complete a video-conference consultation with the provider who is at another location. Once the consultation is complete, and the medication is dispensed to the patient at the rural facility. A seven-year, retrospective cohort study done in Iowa using a clinic-to-clinic telemedicine model found the occurrence of an adverse event utilizing telemedicine abortion to be 0.18% (N=8,765) versus 0.32% (N=10,405) using the standard clinic model.[32] Another study in Iowa assessing changes in abortion services rendered after the introduction of telemedicine abortion, found high acceptability and uptake of medical abortion using the telemedicine model.[31] The findings also indicate that increased access to telemedicine abortion increases overall access and uptake of abortion in the 1st trimester.[31] While clinic-to-clinic telemedicine abortion may be effective in increasing access to abortion services in other states with different medical infrastructures, this model might not currently be effective in Hawai'i as it requires healthcare institutions that deliver care across multiple islands. The unique geography of Hawai'i requires a service delivery model that can easily adapt to the current medical infrastructure.

The direct-to-consumer model of medical abortion, termed TelAbortion, is another promising way of increasing abortion access in Hawai'i. This model removes the necessity of two clinical settings as previously described. The patient and provider can be anywhere in the state and video conference with any internet capable device using a secure connection. The diagnostic work up is completed by the patient in outpatient settings on their home island. Once the patient completes the diagnostic work-up and the consultation, both medications are mailed directly to their home, preventing the need for an in-person visit. This model is currently being studied in Hawai'i by Gynuity, a non-profit research group.[29,30] This successful demonstration project has served over 100 women in Hawai'i, over the past two years, from every island in the state. However, this project is limited to the confines of research due to the Mifeprex Risk Evaluation and Mitigation Strategy (REMS).[33] The REMS prevents dispensing of mifepristone from a pharmacy and requires special registration of providers that dispense the medication in their offices. While the intention of the REMS is to ensure patient safety, mifepristone is a safe medication that does not require special monitoring to ensure public welfare.[34]

The final option for removing geographic barriers to abortion access in Hawai'i is overturning the REMS. The REMS prevents providers from being able to write a prescription for this safe medication and compounds geographic barriers to abortion in Hawai'i. Although overturning the REMS is a national strategy, the ground-work for this effort is starting in Hawai'i. In 2017, the American Civil Liberties Union sued the FDA on behalf of Dr. Graham Chelius in Kaua'i to remove the REMS from mifepristone.[35–37] Dr. Chelius would like to provide abortion care via medical abortion, but is barred from stocking the medication in his practice. He is suing the FDA for the right to write a prescription for the medication so his patients on Kaua'i have access to medical abortion near their homes. If Dr. Chelius is successful in his lawsuit against the FDA, geographic barriers to abortion care in Hawai'i could be vastly alleviated.

Conclusions

Although Hawai'i has progressive health policies overall, not all people in Hawai'i have equitable access to reproductive health care. Undocumented immigrants, service members and their spouses, and those covered by insurance through the federal government are left without insurance coverage for abortion care. Women living in rural areas do not have access to sufficient providers.

These gaps in abortion coverage and care in Hawai'i can be addressed. Some options to address the financial issues would be expanding Hawai'i's Medicaid program to cover abortion for anyone who has insurance that does not cover abortion or reintroducing and passing SB 2341/ HB 2121 to the 2019

Hawai‘i State Legislature. Some ways to address the access to care for rural communities would be expand the abortion provider workforce through ending “physician-only laws,” continue TelAbortion services, and to overturn the REMS for Mifeprex at the national level.

Women in Hawai‘i deserve access to full-spectrum reproductive healthcare, including abortion care. Financial and geographic barriers to abortion access make abortion technically legal for all, but out-of-reach for many. This unjust practice must end in Hawai‘i and nationwide.

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